NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the Investigation of Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and F431. STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130 STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130 STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130 STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130 (X5) COMPLETION DATE FROUDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) This visit was for the Investigation of Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed the plan of find enclosed the plan of corrections encourage.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE (X4) ID PREFIX TAG This visit was for the Investigation of Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and F1000 STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130 (X5) PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CASH PROVIDERS PLAN OF CORRECTION PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please	AND PLAN	OF CORRECTION		A. BUILDING	00		
HILLCREST VILLAGE (X4) ID PREFIX TAG This visit was for the Investigation of Complaint IN00113535, IN00113621, and IN00114469. Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and EXAMPLE PROVIDER OR SUPPLIER JEFFERSONVILLE, IN 47130 ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ALCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDER SPLAN OF CORRECTION (CAS) COMPLETION DATE FO000 Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please			155203	B. WING		08/21/2012	
HILLCREST VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the Investigation of Complaint IN00113535, IN00113621, and IN00114469. Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and EACH.	NAME OF I	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for the Investigation of Complaint IN00113535, IN00113621, and IN00114469. Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and Example 100 process of the provider of the provider of the provider of the plan of correction as our credible allegation of compliance. Please							
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This visit was for the Investigation of Complaint IN00113535, IN00113621, and IN00114469. Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and F0000 Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please		REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
Complaint IN00113535, IN00113621, and IN00114469. Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please							
Complaint IN00113535, IN00113621, and IN00114469. Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and Correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please		This visit was for	or the Investigation of	F0000	Submission of this plan of		
and IN00114469. Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please			•	10000			
Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and FA21 Frovider of the truth of facts alleged or correction set forth on the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please		_			admission or agreement by th	e	
Complaint IN00113535 - Substantiated. Federal/state deficiencies related to the allegations are cited at F332, F425, and F421 the statement of deficiencies. Please accept this plan of correction as our credible allegation of compliance. Please			9.				
Federal/state deficiencies related to the allegations are cited at F332, F425, and F421 Please accept this plan of correction as our credible allegation of compliance. Please		Complaint INO	112525 Substantiated		_	on	
allegations are cited at F332, F425, and Correction as our credible allegation of compliance. Please		_					
allegation of compliance. Please							
F431. I find enclosed the plan of		_	rited at F332, F425, and		allegation of compliance. Plea	se	
		F431.			find enclosed the plan of		
correction for survey ending July							
and acceptive of the acceptance lines		Complaint IN00113621 - Substantiated.					
please find sufficient						mg,	
allegations are cited at F315, F322, F328, documentation providing		_					
F329, F332, F425, and F431. evidence of compliance with the		F329, F332, F42	25, and F431.			he	
plan of correction. The					·		
Complaint IN00114469 - Substantiated. documentation serves to confirm the facility's allecgation of		Complaint IN00	0114469 - Substantiated.			ırm	
Federal/state deficiencies related to the compliance. Thus, the facility		Federal/state de	ficiencies related to the				
allegations are cited at F332, F425, and respectfully requests the granting		allegations are of	cited at F332, F425, and		respectfully requests the gran	ting	
F431. of paper compliance.		F431.			of paper compliance.		
Unrelated deficiencies are cited.		Unrelated defication	iencies are cited.				
Survey dates: August 19, 20, and 21,		Survey dates: A	August 19, 20, and 21,				
2012		2012					
Facility number: 000110							
Provider number: 155203							
AIM number: 100271120		AIM number:	100271120				
Survey team: Jennie Bartelt, RN		Survey team: Jo	ennie Bartelt, RN				
Census bed type:		Census bed type	e:				
SNF: 0							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155203	A. BUILDING B. WING	00	COMPI 08/21	LETED
	PROVIDER OR SUPPLIER EST VILLAGE	203 SP	ADDRESS, CITY, STATE, ZIP COI ARKS AVE RSONVILLE, IN 47130	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	SNF/NF: 75 Total: 75				
	Census payor type: Medicare: 14 Medicaid: 59 Other: 2 Total: 75 Sample: 11 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on August 27, 2012 by Bev Faulkner, RN				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 2 of 46

NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY		
OF CORRECTION	IDENTIFICATION NUMBER:	A RUU DING	00	COMPLETED
	155203			08/21/2012
			ADDRESS, CITY, STATE, ZIP CODE	
PROVIDER OR SUPPLIER				
EST VILLAGE				
SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
NO CATHETER, BLADDER				
assessment, the foresident who enterindwelling cathetes the resident's clin that catheterization resident who is in receives appropriato prevent urinary	facility must ensure that a ers the facility without an er is not catheterized unless ical condition demonstrates on was necessary; and a continent of bladder ate treatment and services of tract infections and to			
Based on record facility failed to resident with his hypertrophy relawhen the resident removed upon he when the physici for post void resipractice affected related to care for catheter from a serious include. The clinical recordindicated of prostatic hype the hospital for serious discharging hospitals.	assess and plan care for a tory of benign prostatic ted to urinary retention at's Foley catheter was appital discharge and an ordered assessment adual. The deficient 1 of 1 resident reviewed allowing removal of Foley ample of 11. (Resident I) : rd for Resident 'I' was 1/12 at 3:15 p.m. The the resident had a history artrophy and had been in aurgery to the foot.	F0315	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident 1 no longer resides in the facility How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential be affected by the alleged deficient practice All resident with foley catheters were assessed and care plan update by DNS/designee related to urinary retention, and post voice residual. Licensed nurses will educated on the policy/procedure for foley catheter care by the DNS/designee, potest included on or before 9/20/12Any resident that has foley catheter removed will I assessed per physician order.	e e e e e e e e e e e e e e e e e e e
	SUMMARY S' (EACH DEFICIEN REGULATORY OR 483.25(d) NO CATHETER, BLADDER Based on the resident who enterindwelling catheter the resident who is in receives appropri to prevent urinary restore as much resident with his hypertrophy relawhen the resident with his hypertrophy relawhen the physici for post void resident who is in receives appropri to prevent urinary restore as much resident with his hypertrophy relawhen the resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the physici for post void resident with his hypertrophy relawhen the resident who is in receives a proper to prevent union resident who is in receives appropri to prevent union resident who is in receives appropri to prevent union resident who is in receives appropri to prevent union resident who is in receives appropri to prevent	DENTIFICATION NUMBER: 155203 PROVIDER OR SUPPLIER EST VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as	DENOVIDER OR SUPPLIER STREET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to assess and plan care for a resident with history of benign prostatic hypertrophy related to urinary retention when the resident's Foley catheter was removed upon hospital discharge and when the physician ordered assessment for post void residual. The deficient practice affected 1 of 1 resident reviewed related to care following removal of Foley catheter from a sample of 11. (Resident I) Findings include: The clinical record for Resident 'I' was reviewed on 8/21/12 at 3:15 p.m. The record indicated the resident had a history of prostatic hypertrophy and had been in the hospital for surgery to the foot. The urologist's orders from the discharging hospital on 8/14/12 at 11:30	PROVIDER OR SUPPLIER ST VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is innontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to resident with history of benign prostatic hypertrophy related to urinary retention when the resident's Foley catheter was removed upon hospital discharge and when the physician ordered assessment for post void residual. The deficient practice affected 1 of 1 resident reviewed related to care following removal of Foley catheter from a sample of 11. (Resident I) Findings include: The clinical record for Resident 'I' was reviewed on 8/21/12 at 3:15 p.m. The record indicated the resident had a history of prostatic hypertrophy and had been in the hospital for surgery to the foot. The urologist's orders from the discharging hospital on 8/14/12 at 11:30

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 3 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155203	B. WIN			08/21/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			ARKS AVE		
HILLOPE	ST VILLAGE				RSONVILLE, IN 47130		
HILLONE	OT VILLAGE			JEFFER	CSONVILLE, IN 47 130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	mark] PVR's [po	ost void residuals] X 2			responsible for monitoring the	he	
	[twice] [seconda	ry to] removal. Reanchor			3 day Bladder Continent		
		er than] 300." The			Assessment and ensuring po		
		ian's orders from the			void residuals are completed		
					per order. DNS/designee wil	l l	
		oital on 8/14/12 at 12:55			monitor compliance by		
		out were not limited to,			reviewing the 3 Day Bladder		
	"Send to Hillcre	st" and "Follow PVR			Continent Assessment upon		
	[post void residu	ıal] orders at Hillcrest."			completion. Non-compliance with these procedures will	е	
					result in further education		
	A notation on th	e hospital transfer form			including disciplinary		
		*			action. What measures will b	ne.	
	indicated, "F/C [Foley catheter] out 11:30 [check mark] PVR X 2 Reanchor FC if				put into place or what syster		
	-	/ K A 2 Realichol FC II			changes will be made to		
	PVR > 300."				ensure that the deficient		
					practice does not		
	The American S	enior Communities			recur? Licensed nurses will	be	
	Admission Asse	ssment indicated the			educated on the policy/		
	resident was adr	nitted on 8/14/12 at 6:00			procedure for foley catheter		
		ment indicated the			care by the DNS/designee, p	ost	
	l -	have a Foley catheter and			test included on or before		
					9/20/12Any resident that has		
	was not continer	nt prior to admission.			foley catheter removed will		
					assessed per physician orde	er.	
		mission Nursing Care			The charge nurse will be	•	
	Plan, dated 8/14	/12, failed to indicate a			responsible for monitoring the	ne	
	problem, goal, o	r interventions related to			3 day Bladder Continent	4	
	*	re need in regard to the			Assessment and ensuring po void residuals are completed		
		of the Foley catheter and			per order.DNS/designee will	ı	
		•			monitor for compliance		
		ring for urinary retention			Non-compliance with these		
	and checking for	r post void residual.			procedures will result in		
					further education including		
	Physician's adm	ission orders, dated			disciplinary action. How the		
	8/14/12, include	d, but were not limited to,			corrective action(s) will be		
	· · · · · · · · · · · · · · · · · · ·	[check mark] PVR X 2.			maintained to ensure the		
	Reanchor F/C if	-			deficient practice will not red	cur,	
	Realient 17C II	1 110 200.			i.e., what quality assurance		
	Ī		1		Ī		ī

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155203	B. WIN			08/21/2012
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLI LIER			203 SP	ARKS AVE	
HILLCRE	ST VILLAGE			JEFFEF	RSONVILLE, IN 47130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		Note, dated 8/14/12 at			program will be put into place? The CQI skills validation	
		ided an assessment of the			tool for foley catheters will be	""
		d to the urinary system,			utilized weekly x 4 weeks,	
	the note indicate	d, "Pt has not void [sic]			monthly x 6 months and quarte	erly
	_	itted [a period of four			thereafter Findings from the C	
	hours at the time	of the note or 10+ hours			process will be reviewed mont	hly
	since the Foley of	eatheter was removed at			and an action plan will be implemented as needed for an	W
	the hospital], dra	inage & blood noted on			deficient practices below the 9	
	penis"				threshold CQI team will	
					determine need for further	
	The next Nurse's	Note, dated 8/15/12 at			review	
	4:00 a.m., indica	ited related to the				
	resident's urinary					
	·	&B [bowel and bladder],"				
	and was signed b	= -				
	and was signed t)				
	The next Nurse's	Note, dated 8/15/12 at				
		eated an assessment of the				
	resident, includin					
	[incontinent] B&	-				
		noted some anxiety. MD				
	_	will be in to see res this				
	afternoon."	will be in to see les tills				
	ancinoon.					
	Documentation i	n Nurse's Notes from				
		gh 8/15/12 at 11:00 a.m.,				
	`	e assessment and care				
	_	to possible urinary				
	•	ing bladder distension				
		at failed to void, checking				
	•	al, including amount of				
		post void residual, or				
	description of the	e urine.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 5 of 46

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
11112 12111	or confidence.	155203		LDING		08/21/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ARKS AVE		
HILLCRE	ST VILLAGE			JEFFER	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ities of Daily Living]		TAG			DATE
	-	anks for Bladder					
	_	1/12. On 8/15/12, in the					
		n on night shift was					
		In the Incontinent					
	· · · · · · · · · · · · · · · · · · ·	12 was indicated "1,200"					
		d X 3 on day shift and a					
	blank space on e	-					
	•	-					
	On the Medication	on Record next to the					
	entry for "F/C o	ut 11:30, [check mark]					
	PVR X 2. Reand	chor F/C if PVR > 300 ,"					
	were a nurse's in	itials signed on the line					
	between the date	es of 8/12 and 8/13/12 and					
	between the date	es on the line of 8/13 and					
		or to the resident's					
	admission. The						
		ould not be determined,					
		ation was written across					
		ifts. After the initials					
		ritten 200. On the line					
	•	00 a.m. to 3:00 p.m.) on					
		urse's initials with 800 cc					
	next to the initial	IS.					
	The next Nurse's	Note, dated 8/15/12 at					
		ated, "MD in to see. N.O.					
	•	razolam [antianxiety					
		nchor F/C and D/C					
	[discontinue] in						
	PVRs"	-					
		e for 8/15/12 at 5:00 p.m.,					
	indicated a Foley	catheter was placed.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 6 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	ĺ	LDING	NSTRUCTION 00	(X3) DATE COMPL 08/21	ETED
	PROVIDER OR SUPPLIER			203 SPA	ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO! (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
		r 8/18/12 at 11:45 a.m., ident was sent to the nation.					
	indicated the resi	r 8/18/12 at 5:00 p.m., ident was admitted to the ment of a urinary tract					
	(DON), Nurse C Nursing from a s	or, Director of Nursing onsultant, Director of ister facility, and Nurse were interviewed					
	of the Foley cath urinary retention The Administrate	s care related to removal eter and the potential for on 8/21/12 at 5:15 p.m. or indicated the facility					
	residual. The DO indicated she wo post void residua	checking for post void ON from the sister facility uld expect the checks for all to be completed within er a Foley catheter was					
	removed. She in had not voided, I assessed for urin	dicated if the resident ne would need to be ary retention, such a istended bladder. The					
	Medical Records initials on the Mo RN #11's initials	Nurse indicated the edication Record were . The Medical Records					
	and RN #11 told Nurse she though	the Medical Records at she had completed the roid residual checks on					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 7 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155203	A. BUILDING B. WING	COMPLETED 08/21/2012
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STAT 203 SPARKS AVE JEFFERSONVILLE, IN 4	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE O TO THE APPROPRIATE ZIENCY) (X5) COMPLETION DATE
IAU	8/15/12 at about midnight and 4:00 a.m. The Administrator stated to the Medical Records Nurse on the phone, "Tell her I want a written statement about it." The American Medical Directors Association's Clinical Practice Guideline for Urinary Incontinence indicated related to Postvoid Residual Testing, "When urinary retention is suspected on the basis of history, physical exam, or risk factors, a postvoid residual (PVR) rest may be helpful. The test should be performed within a few minutes after a continent or incontinent void. Preferably, the volume of the void should be measured, but if it is an incontinent void, the amount of incontinence (i.e. small, medium, or large) should be recorded along with the PVR volume. A residual volume that is not measured within a few minutes after a void is not helpful" This federal tag is related to Complaint IN00113621. 3.1-41(a)(1) 3.1-41(a)(2)		DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 8 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155203	A. BUI. B. WIN			08/21/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARKS AVE		
HILL CRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
F0322		LSC IDENTIFFING INFORMATION)		TAG	DE TELEKCT,		DATE
SS=D	483.25(g)(2) NG TREATMENT	SERVICES - RESTORE					
00-D	EATING SKILLS	ACENTIOLS TRESTORE					
		nprehensive assessment of					
		cility must ensure that a					
		d by a naso-gastric or					
		receives the appropriate					
		vices to prevent aspiration nea, vomiting, dehydration,					
	metabolic abnorm						
		ulcers and to restore, if					
	possible, normal	eating skills.					
	Based on observa	ation and record review,	F03	22	What corrective action(s) will	l	09/20/2012
	the facility failed	I to ensure residents who			be accomplished for those		
	received nutrition	n by gastrostomy tube			residents found to have been	1	
	were provided n	nedications by			affected by the deficient		
	gastrostomy tube	e in accordance with			practice?Resident D and Resident F are now receiving	i	
	acceptable practi	ce for 2 of 2 residents			medications via g-tube per	,	
		ng medication by			acceptable nursing		
		e in a sample of 11			practices.How other resident	s	
	residents. (Resid	•			having the potential to be		
	1051401105. (110510				affected by the same deficier		
	Findings include				practice will be identified and what corrective action(s) will		
	i mamgs merade	•			be takenAll residents recieving		
	1 On 8/10/12 at	: 10:05 a.m., LPN #15			medications per g-tube have	9	
		· ·			the potential to be affected by	y	
	-	eparing medications for			the alleged deficient		
		y gastrostomy tube to			practice.Residents receiving		
		N #15 crushed the			medications per g-tube were		
		hered the medications			assessed by DNS/designee to		
	11	d entered the resident's			ensure residents are receiving medications in accordance	ıg	
		ident's bathroom, she			with acceptable		
	•	ed medications into a cup			practices. Licensed nurses w	/ill	
	and mixed with v	warm water. She mixed a			be educated on administering		
	powdered medic	ation in a cup with warm			medications per g-tube by		
	water, and obtain	ned a cup of water for			the SDC/designee on or befo	re	
	flushing the resid	dent's gastrostomy tube.			9/20/12, post test		
	5	2			includedlicensed nurses will	be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 9 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		155203	B. WIN			08/21/2012
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	8			ARKS AVE	
HILLODE	ST VILLAGE				RSONVILLE, IN 47130	
THELOILE				JEI I EI	NOONVILLE, IIV 47 130	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	LPN #15 donned	d gloves, stopped the			observed adminsitering	
	resident's feeding	g pump for her nutrition			medications per g-tube bythe	9
	by feeding tube	and disconnected the			SDC/designee on or before	
		m the pump tubing.			9/20/12 with a skills validatio	
	_	ig tube placement or			completedDNS/designee will monitor for	
		-			complianceNon-compliance w	uith .
		trostomy tube, LPN #15			this procedure will result in fur	• • • • • • • • • • • • • • • • • • •
		cups of crushed and			training including disciplinary	
	-	eations in solution,			action. What measures will be	e
	flushed the tube	with water, reconnected			put into place or what systen	
	the feeding pum	p tube, and restarted the			changes will be made to	
	resident's feedin	g.			ensure that the deficient	
	·				practice does not	
	2 On 8/19/12 as	t 10:45 a.m., LPN #15			recur? Licensed nurses will l	be
		·			educated on administering	
	1	eparing medications by			medications per g-tube by	
	, ,	e for Resident F. LPN			the SDC/designee on or befo	re
	#15 crushed the	medications and prepared			9/20/12, post test	
	powdered and lie	quid medications, and			includedlicensed nurses will	be
	entered Resident	t F's room. She mixed the			observed adminsitering	
	medications with	h water in cups. LPN #15			medications per g-tube bythe SDC/designee on or before	,
		stopped the continuous			9/20/12 with a skills validation	n
	_	np, disconnected the			completedDNS/designee will	
		-			monitor for	
		e from the pump, and			complianceNon-compliance w	vith
	1	g placement or flushing			this procedure will result in	
	_	the cups of crushed and			further training including	
	powdered medic	eations mixed with water			disciplinary action. How the	
	into the tube, flu	shed with water and			corrective action(s) will be	
	reconnected the	tube and started the			maintained to ensure the	
	feeding.				deficient practice will not rec	ur,
					i.e., what quality assurance	
	The facility peli	ay related to Mediaction			program will be put into plac	
		cy related to Medication			The CQI audit tool for g-tube	
		Guidelines Via Enteral			administration will be	
	_	ided by the Medical			completed weekly x4 weeks, monthly x 6 months and	
	Records Nurse o	on 8/21/12 at 2:20 p.m.			quarterly thereafter Findings	
	The policy indic	ated, "Turn off the			qualities y therealter i mamys	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 10 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155203	B. WING		08/21/2012
HILLCRE	PROVIDER OR SUPPLIE		203 SF JEFFE	ADDRESS, CITY, STATE, ZIP CODE PARKS AVE RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	feeding pump. tubing from the feeding tube pla gastric contents (forcing air into establish that it than the lung) medication adm approximately 3	Disconnect the feeding enteral tubingCheck for accement by aspiration of or by auscultation the tube and listening to is in the stomach, ratherFlush tube before	TAG	from the CQI process will be reviewed monthly and an action plan will be implemented as needed for any deficient practic below the 95% threshold. The CQI team will determine need further review.	DATE DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 11 of 46

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155203	B. WING		08/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			PARKS AVE	
HILLORE	ST VILLAGE			RSONVILLE, IN 47130	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0328	483.25(k)				
SS=D		RE FOR SPECIAL NEEDS			
		ensure that residents			
	following special	eatment and care for the			
	Injections;	SELVICES.			
	Parenteral and er	nteral fluids:			
		rostomy, or ileostomy care;			
	Tracheostomy ca				
	Tracheal suctioning				
	Respiratory care;				
	Foot care; and				
	Prostheses.				
	Based on observ	ation, interview and	F0328	What corrective action(s) will	09/20/2012
	record review, th	e facility failed to ensure		be accomplished for those	
	assessment and p	planning of care for		residents found to have been	1
	residents with re	spiratory care needs for 2		affected by the deficient	
	of 2 residents rev			practice?Resident C and F ar	
		cations by nebulizer in a		now receiving respiratory car based on their assessed nee	
	-	idents. (Residents C and		and plan of care. How other	us
		idents. (Residents C and		residents having the potentia	n
	F)			to be affected by the same	"
				deficient practice will be	
	Findings include	:		identified and what corrective	e l
				action(s) will be taken?All	
	1. On 8/19/12 at	: 10:45 a.m., LPN #15		residents recieving nebulizer	.
		eparing and administering		treatments have the potentia	
		Resident F, including a		to be affected by the alleged	
		ed Budesonide INH 0.5		deficient practiceAll residents	
				receiving	
	_	al per nebulizer twice		medications by nebulizer were	
	_	ident's bedside, the nurse		assessed and care plan updat by DNS/designee to ensure	c u
	checked the resid	•		residents are receiving	
	obtained the resi	dent's nebulizer mask,		medications as prescribed and	ı
	poured the medic	cation into the medication		per acceptable	
	chamber, assisted	d the resident with the		practices. Licensed nurses w	iII
	-	d the treatment. The		be educated on	
	*	ess the resident's breath		administering/assessing	
		residents of earli		a resident recieving a nebuliz	zer
			1	<u> </u>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 12 of 46

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLETED
		155203	A. BUII B. WIN			08/21/2012
			b. Will		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ARKS AVE	
	ST VILLAGE				RSONVILLE, IN 47130	
HILLORE	ST VILLAGE			JEFFER	RSONVILLE, IN 47 130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	sounds.				treatment by SDC/designee of	
					or before 9/20/12 with post te	
	2 The clinical r	record for Resident C was			included.Licensed nurses wi	11
		0/12 at 5:30 p.m.			be observed	
	1 CVICWED OII 6/2	0/12 at 3.30 p.m.			administering/assessing	
					resident during a nebulizer	
		or 8/10/12 at 10:15 a.m.			treatment using the nebulize	
	indicated the res	ident experienced			skills check off.DNS/designe	
	shortness of air	with oxygen saturation at			will monitor for complianceN	on
	82 to 85% on ro	3.0			compliance with these	,
					procedures will result in furth	ier
	Dhygiaian's arda	ra vyora raggiyad on			education including disciplinary action.What	
	Physician's orders were received on				measures will be put into pla	CO
		a.m., for "Chest x-ray			or what systemic changes wi	
	today" and "Min	nineb treatment Albuterol			be made to ensure that the	"
	now." The Care	Plan Update section of			deficient practice does not	
	the order indicat	ed a problem of increased			recur? Licensed nurses will I	be
	congestion goal	of decreased congestion			educated on	
	1 -	interventions of "x-ray,			administering/assessing	
	T -				a resident recieving a nebuliz	zer
	· ·	nd seen by Nurse Pract			treatment by SDC/designee of	on
	[Practitioner]."				or before 9/20/12 with post te	est
					included.Licensed nurses wi	II
	A Physician's Pr	ogress Note, dated 8			be observed	
	/10/12, indicated	d, "S [subjective]: Pt			administering/assessing	
	[patient] aspirate	ed yesterday. N&V			resident during a	
		niting]. Had episode of			nebulizer treatment using the)
	-	CXR [chest x-ray] & O2			nebulizer skills check	
	, , ,	2 3			off.DNS/designee will	
		d. O [objective]: General			monitor for complianceNon	
	_	comfortably Heart -			compliance with these	,
	distant Lungs C	ΓAB [clear to auscultation			procedures will result in furti	iei
	bilaterally]"				education including disciplinary action. How the	
					corrective action(s) will be	
	The results of th	e chest x-ray, dated			maintained to ensure the	
		ed infiltrates in the lower			deficient practice will not rec	ur.
	· ·				i.e., what quality assurance	~··,
	lobes of the righ	ı iung.			program will be put into plac	e?
					g so par piao	-

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 13 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155203	B. WING			08/21/2012
VIII OF P			'	STREET A	ADDRESS, CITY, STATE, ZIP CODE	ı
NAME OF P	PROVIDER OR SUPPLIE	R		203 SP/	ARKS AVE	
	HILLCREST VILLAGE			JEFFEF	RSONVILLE, IN 47130	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	<u> </u>	DATE
	_	ers, dated 8/10/12,			The CQI tool for nebulizer treatment will be utilized	
		ck [antibiotic] per			weekly x4, monthlyx6 and	
	directions. DX	[diagnosis] URI [upper			quarterly thereafter The	
	respiratory infec	ction]" and "Albuterol			nebulizer skills check off will	
	mini-neb tx's [tr	eatments] 0.83%. Inhale			be utilized for licensed nurse	
	1 vial TID [thre	e times daily] X 4 days."			to ensure nurses are	
	-	failed to indicate oxygen			administering nebulozer	
	was ordered. The Care Plan Update section of the order form indicated a problem of URI, goal of "Will be free				treatments per order and	
					assessing resident prior to,	
					during and after administering	
	1 2				treatment. Findings from the C process will be reviewed month	
	from S/S [signs and symptoms] URI by 8/16/12," and interventions of "Meds				and an action plan will be	illy
	· ·				implemented as needed for ar	ıv
		er MD order, Mini-nebs			deficient practices below the 9	
	per MD order, E	Encourage fluids."			threshold. The CQI team will	
					determine need for further	
	A Nurse's Note,	dated 8/11/12 at 2:15			review.	
	a.m., indicated,	"Res resting abed ABT				
	[antibiotic] - UF	RI, [symbol for no] ASE				
		fects] noted mini-neb tx				
	[treatment] as or	-				
	-	en & unlabored. [Symbol				
		oted. O2 [oxygen] sats				
		2 20 3				
		on RA [room air]. Will				
	cont. [continue]	to monitor."				
	Nursing Notes f	ailed to indicate				
	assessment for s	signs and symptoms of				
		nonitoring of the resident				
		5:00 p.m., a period of				
	more than 12 hours. Nurse's Notes on 8/11/12 at 5:00 p.m., indicated the					
		-				
		n her wheel chair and was				
	transferred to th	e nospital.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 14 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155203	B. WING			08/21/	2012
			1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u>t</u>			ARKS AVE		
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID				(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	The Medication	Administration Record					
		indicated the resident					
	_	ol minineb treatments on					
	_	o.m. and on 8/11/12 at					
	8:00 a.m. and 2:00 p.m.						
		licy related to Pulmonary					
	~	s provided by the					
	Medical Records	s Nurse on 8/21/12 at					
	2:20 p.m. The p	olicy indicated for					
	Procedure: Handheld Nebulizer indicated						
	before initiating	the treatment					
	"Performs pati	ent assessment (pulse,					
	breath sounds, re	espiratory rate,					
	etc.)Correctly	•					
	,	rmation into patient's					
		" Attached to the the					
		oulizer Treatment Flow					
		entation of care related to					
		atment, which provided					
	_	nenting heart rate,					
		and breath sounds before					
		g treatment, and after					
	treatment, and to	otal minutes of the					
	treatment.						
	During interview	y on 8/21/12 at 4:35 p.m.,					
	the Medical Rec	ords Nurse indicated no					
	Nebulizer Treatr	nent Flow Sheet could be					
	located for Resid	lent C.					
	During interview	on 8/21/12 at 5:15 p.m.,					
	_	Jursing indicated the 24					
		been checked, and no					
	nour reports nau	occin checked, and no					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 15 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155203	A. BUILDING B. WING	00	COMPLETED 08/21/2012			
	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
	further information related to assessment and monitoring of Resident C was available.						
	This federal tag is related to Complaint IN00113621.						
	3.1-47(a)(6)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 16 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
ANDILAN	OF CORRECTION	155203	A. BUILDING	00	08/21/2012
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/2 1/20 12
NAME OF F	PROVIDER OR SUPPLIE	R		PARKS AVE	
HILLCRE	ST VILLAGE			RSONVILLE, IN 47130	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0329 SS=D	UNNECESSARY Each resident's of from unnecessar drug is any drug dose (including of excessive duration monitoring; or wifor its use; or in to consequences we should be reduce combinations of Based on a complete in the facion resident, the facion residents who had drugs are not give antipsychotic drugterat a specific of documented in the residents who use receive gradual of behavioral intervicent intervicent in the sed of these drugs. Based on record facility failed to receiving anticolor monitored related	drug regimen must be free by drugs. An unnecessary when used in excessive duplicate therapy); or for on; or without adequate thout adequate indications he presence of adverse which indicate the dose and or discontinued; or any other reasons above. The prehensive assessment of a lity must ensure that ave not used antipsychotic are these drugs unless and the clinical record; and the eniocal record; and the eniocal record; and the entions, unless clinically in an effort to discontinue. I review and interview, the ensure a resident agulant medications was add to therapeutic dosing	F0329	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident A is being	ı
	for 1 of 1 reside	nt reviewed related to		monitored for coumadin	
		py in a sample of 11		therapy per physician	
	residents. (Resi	dent A)		order.How other residents	
	Findings include			having the potential to be affected by the same deficier practice will be identified and what corrective action(s) will	d l
		ord for Resident A was		be taken?All residents recieving an anticoagulant	
		9/12 at 7:25 a.m. The		have the potential to be	
	record indicated	the resident was		The state potential to be	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 17 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155203		LDING		08/21/	2012
			B. WIN		ADDRESS OF STATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
			203 SPARKS AVE				
HILLCRE	HILLCREST VILLAGE			JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	readmitted to the	e facility on 7/25/12			affected by the alleged	ï	
		alization for diagnoses			deficient practiceAll resident	s	
		ot limited to, pulmonary			receiving an anticoagulant		
	_				were assessed		
	embolism (blood	d clot in the lung).			and monitored for therapeuti	С	
					dosing by		
	A physician's or	der, dated 7/26/12,			DNS/designee. Licensed		
	included, but was not limited to, "Give				nurses will be educated on		
	Coumadin [antic	coagulant medication] 5			monitoring residents on		
	_	•			anti-coagulant therapy by the	9	
	mg dly [daily] @ 16:30 [4:30 p.m.]" and				SDC/designee on or before		
	"Repeat INR [International Normalized				9/20/12, post test		
	Ratio - blood test related to clotting time]				included. Monitoring of		
	Sat [Saturday] 7.	/28/12." The Care Plan			warfarin/Coumadin will be logg	gea	
	Update section of	of the order indicated,			on the Coumadin/warfarin tracking log each time a reside	ont	
	"Problem: Labs	; Goal: Labs WNL			has a PT/INR level drawn to	511L	
		imits]; Intervention:			include the date the level was		
	-	lications] per order. Labs			drawn, the current dose reside	ent	
	-	neations] per order. Labs			is receiving, the INR result, M		
	as indicated."				notification and dosage		
					changes/comments.DNS/desi	gn	
	A Physician Tel	ephone Order received			ee will monitor for		
	8/6/12, indicated	l, "Notified MD of lab PT			compliance.Non-compliance	with	
	18.6/INR 1.8. П	Name of physician's staff]			these practices will result in		
	-	ed back. Coumadin 3 mg			further education including		
		•			disciplinary action. What		
		d [every day] (stays			measures will be put into pla		
		continue] Lovenox			or what systemic changes wi	ill	
	1	oagulant medication].			be made to ensure that the		
	Recheck PT/INF	R on Thursday (8/9/12).			deficient practice does not	L _	
	Read back above	e is correct."			recur? Licensed nurses will I	oe	
					educated on monitoring		
	Documentation i	in Nurse's Notes, on the			residents on anti-coagulant therapy by the SDC/designed		
					on or before 9/20/12, post tes		
		Treatment Records, and			included. Monitoring of	••	
		on of the clinical record			warfarin/Coumadin will be logo	ned	
	failed to indicate	e blood was obtained or			on the Coumadin/warfarin	,	
	results reported	for the Protime/INR			tracking log each time a reside	ent	
	ordered for 8/9/1	12.			has a PT/INR level drawn to		

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155203	A. BUILDING B. WING	00	COMPLETED 08/21/2012			
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Ditte			
	During interview on 8/21/12 at 11:15 a.m., the Director of Nursing phoned the lab. She indicated the lab staff told her the last PT/INR for Resident A was completed on 8/6/12. A Physician's Telephone Order was obtained 8/21/12 for "Obtain PT/INR." This federal tag is related to Complaint IN00113621. 3.1-48(a)(3)		include the date the level was drawn, the current dose reside is receiving, the INR result, Monotification and dosage changes/comments. All physic orders are reviewed daily in the morning clinical meeting to ensure labs are vDNS/design will monitor for compliance. Non-compliance these practices will result in further education including disciplinary action. How the corrective action(s) will be maintained to ensure the deficient practice will not reciple, what quality assurance program will be put into place the CQI audit tool for coumadin monitoring will be utilized weekly x4, monthly xand quarterly thereafter Findings from the CQ process will be reviewed mone and an action plan will be implemented as needed for an deficient practices below the Square threshold. The CQI team will determine need for further review	ent ID ian ie ee with cur, ee? ca6 CQI thly			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 19 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155203	B. WIN			08/21/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
HILLODE	ST VILLAGE			203 SPARKS AVE JEFFERSONVILLE, IN 47130			
			JEFFE		ASONVILLE, IN 47 130		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0332 SS=E	483.25(m)(1) FREE OF MEDIC OF 5% OR MORE The facility must e medication error r greater. Based on observe interview, the fac medications were residents with an 5%. The deficient residents reviewed administration in residents. Nine e administration w	cation error rate of less than a sample of 11 errors in medication error in medication	F03		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Resident D, Resident A, Resident E, and Resident F are recieving medications per physician orders and nursi standards of practice. How ot residents having the potentia to be affected by the same deficient practice will be	nt : ng her	DATE 09/20/2012
	medication error (Residents D, A,	rate of 22.5%.			identified and what corrective action(s) will be taken?All residents have the potential to be affected by the alleged		
	Findings include				deficint practiceLicensed nurses will be in-serviced on o before 9/20/12 by the		
	was observed pro Resident D. Dur	2 10:05 a.m., LPN #15 eparing medications for ring interview at this time ed she was running a			SDC/designee on administerin medications to include timeline and availabilitySkills check offs will be completed for licensed nurses per the SDC/designee	ess	
		e medications included,			onmedication administration of	n or	
		ited to, the following:			before 9/20/12A 100% audit of	all	
	A. An unlabeled	l Advair inhaler.			labels will be conducted to ensine legible and in place- any findin will be reported to pharmacy a replaced.DNS/designee will be responsible for complianceNor	gs nd	
		ER, inhale 6 puffs by			compliance with these practice		
	mouth every four	r hours.			will result in further education includingdisciplinary action W		
	C. The following	g medications ordered by			measures will be put into pla		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 20 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155203	1			08/21/2012
			B. WIN		ADDRESS OF STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIER	2		1	ADDRESS, CITY, STATE, ZIP CODE	
	·OT \ /// A OF		203 SPARKS AVE			
HILLCRE	ST VILLAGE			JEFFER	RSONVILLE, IN 47130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	gastrostomy tube	e: Digoxin, aspirin, and			or what systemic changes w	ill)
	cholestyramine.	<i>8</i> - ,			be made to ensure that the	
	choicstyrainine.				deficient practice does not	
					recur? Licensed nurses will be	e
	LPN #15 crushe	d the medications for			in-serviced on or before 9/20/1	12
	gastrostomy tube	e administration, gathered			by the SDC/designee on	
		and supplies and entered			administering medications to	
		om. In the resident's			include timliness and	
					availability.Skills check offs wil	
	_	oured the crushed			completed for licensed nurses	
		a cup and mixed with			all shifts per the SDC/designed	
	warm water. Sh	e mixed a powdered			on medication administration of	
	medication in a cup with warm water, and obtained a cup of water for flushing the				or before 9/20/12.DNS/design	ee
					will be responsible for	ith
	•	stomy tube. LPN #15			compliance.Non compliance w these practices will result in	nun
	_	•			further education	
		stopped the resident's			includingdisciplinary action Ho	w.
	• • •	or her nutrition by feeding			the corrective action(s) will b	
	tube and disconr	nected the feeding tube			maintained to ensure the	
	from the pump to	ubing. Without checking			deficient practice will not rec	eur.
	tube placement of	or flushing the			i.e., what quality assurance	,
	•	e, LPN #15 administered			program will be put into plac	e?
		ned and powdered			The CQI audit tool	
	•	•			for pharmacy services will be	e
	· · · · · · · · · · · · · · · · · · ·	shed the tube with water,			completed weekly x4,monthl	
	reconnected the	feeding pump tube, and			x2 and quarterly x 1	
	restarted the resi	dent's feeding.			quarter.The skills checkoff w	dll dill
					be completed weekly x4 wee	ks,
	LPN #15 shook	the canister of Advair and			monthly x6 months and	
		o puffs, one quickly after			quarterly thereafter. Findings	
					from the CQI process will be	
		second shake or time			reviewed monthly and an	
		outh was not rinsed with			action plan will be	
	water. Immedia	tely LPN #15			implemented as needed for a	_
	administered 6 s	uccessive puffs of the			deficient practices below the	
	Combivent inhal	ler without pausing			95% threshold. The CQI team	
		The resident requested the			will determine need for furthe	er
		•			review.	
	_	r tracheostomy at that				
	time.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 21 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO. LDING	NSTRUCTION 00	COMPL		
		155203	B. WIN			08/21/	2012
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ARKS AVE		
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	reviewed on 8/2 record indicated for August 2012 limited to, a. An order origindicated, "Adva [aerosol], inhale twice daily - CO pulmonary disea indicated the me for administration on 8/22/12 at 7: package insert in http://us.gsk.comir_hfa.pdf indicaBreathe out thr push as much air can 3Right out, take your fir After you have be take the inhaler of close your mouth long as you can, breathe normally seconds and shall seconds. Repeat After you finish	dication was scheduled in at 9:00 a.m. 00 a.m., review of aformation on-line at an/products/assets/us_advasted the following: "2. rough your mouth and after the spray comes ager off the canister. For eathed in all the way, but of your mouth and and the following in the way, but of your mouth and and the following in the way, but of your mouth and and the following in the way, but of your mouth and and the following in the way, but of your mouth and and the following in the way, but of your mouth and and the following in the way, but of your mouth and and the following in the way, but of your mouth and and the following in the way, but of your mouth and and the following in the way, but of your mouth and the way, but of your mouth					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 22 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155203	A. BUII	LDING	00	COMPLETED 08/21/2012		
		100200	B. WIN		DDDDGG OWN CTATE OR CODE	00/21/	20.2	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
HILLCRE	ST VILLAGE			203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE	
	_	inally received 4/5/12						
	· ·	oivent AER, inhale 6						
		urs - DX [diagnosis]						
		re." The orders indicated						
	the medication w							
		very four hours beginning						
	•	a scheduled dose due at						
	8:00 a.m. The m							
		east one hour and five						
		one hour before/one						
	hour after the sch	neduled dose time.						
	On 8/22/12 at 7:1	15 a.m., review of						
		formation on-line at						
		hringer-ingelheim.com/B						
	IWebAccess/Vie							
		&folderPath=/Prescribin						
		Is/Combivent+IA/combiv						
	_	the following: "4.						
	-	er vigorously for at least						
		PORTANT: Vigorous						
		ast 10 seconds before						
	_	y important for proper						
		ance 5. Breathe out						
		hrough your mouth 6.						
	, ,	e) slowly through your						
		same time spray the						
		r mouth 7. Hour your						
	-	ond, remove the mouth						
		mouth and breathe out						
	-	it approximately 2						
	•	ne inhaler vigorously for						
	· ·	ds again, and repeat						
	Steps 5 to 7"	5, 						
	•		1					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 23 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		LDING	NSTRUCTION 00	(X3) DATE COMPL 08/21/	ETED	
	PROVIDER OR SUPPLIER		203 SP/	ADDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAG	2. On 8/19/12 at was observed procession and indicated the EDK. The madministered. 2. On 8/19/12 at was observed procession and indicated the result on the medication and indicated the EDK. The madministered.	to 10:25 a.m., LPN #15 eparing medications for medications included, ited to, medications /s: 40 mg, one by mouth iew at this time, LPN #15 ident had a dose of the medication was not on cart, and she would be EDK (Emergency Drug dication. If the resident's room, gas, and administered the pared. She proceeded to Room, checked the EDK, as medication was not in the content of the resident A was 19/12 at 7:25 a.m. ite orders for August out were not limited to,	IAG	DETCHACTY		DATE
	_	inally dated 1/21/11, for mg tab, take 1 tablet by ly. DX: CHF				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 24 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE : COMPL 08/21/	ETED
	ROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	[congestive heard indicated the medicated the medicated p.m. The medical least 25 minutes before/one hour adosing time. b. An order origo "Irbesartan [Avatablet by mouth of Hypertension." 3. On 8/19/12 a was observed proceed the medication has the medication has from the pharmathat sometimes of pharmacy is slow. The clinical recorreviewed on 8/21 Physician's Order included, but we following medication in the pharmathat sometimes of pharmacy is slow. The clinical recorreviewed on 8/21 Physician's Order included, but we following medication in the pharmathat sometimes of pharmacy is slow. The clinical recorreviewed on 8/21 Physician's Order included, but we following medication in the pharmathan included, but we following medication in the pharmathan included included, but we following medication in the pharmathan included inclu	t failure]." The orders dication was scheduled in at 9:00 a.m. and 5:00 tion was administered at after the one hour after the scheduled inally dated 7/25/12, for pro] 150 mg tab, take 1 once daily. DX: It 10:40 a.m., LPN #15 eparing medications for ing interview at this time, ed the resident also dose of Alfuzosin, but ad not yet been received cy. LPN #15 indicated on the week-end the vito deliver medications. was not administered. In drop Resident E was 1/12 at 10:05 a.m. is for August 2012 re not limited to, the ation orders: An order ed 7/28/12 for "Alfuzosin y [daily] (BPH) [benign]					
	4. On 8/19/12 at	: 10:45 a.m., LPN #15					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 25 of 46

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JETIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155203	B. WING			08/21/	2012
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP CODE		
	-OT \				ARKS AVE		
HILLCRE	ST VILLAGE			JEFFER	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	eparing and administering					
medications labeled as follows for							
	Resident F:						
	A. LPN #15 obta						
		5mg/5ml from the					
		ver. She indicated a spill					
		he information on the					
	medication label	l. She was observed to					
	measure 5 ml of	the medication into a					
medication cup.							
	B. Budesonide INH 0.5 mg/2ml, use 1						
	vial per nebulize	er twice daily.					
	C. Carvedilol 3.	125 mg tab, 1 by mouth					
	twice daily.	-					
	LPN #15 crushe	d the medications and					
	entered Resident	t F's room and mixed the					
	medications and	with water in cups. LPN					
	#15 donned glov	•					
	continuous tube						
		e gastrostomy tube from					
	the pump, and w	•					
		shing the tube, poured the					
		d powdered medications					
	-	er into the tube, flushed					
		reconnected the tube and					
		ng. LPN #15 then set up d the nebulizer treatment.					
	and administered	u me nebunzer treatment.					
	The allower to	and fan Daaidant E					
		ord for Resident F was					
	reviewed on 8/2	1/12 at 10:15 a.m. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 26 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION 00	(X3) DATE (COMPL	
THEFTERN	or condition	155203		LDING		08/21/	
		.55255	B. WIN		DDRESS, CITY, STATE, ZIP CODE	00/2 !!	
NAME OF I	PROVIDER OR SUPPLIER				ARKS AVE		
HILLCRE	ST VILLAGE				RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	EACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		*		TAG	DEFICIENCY)		DATE
		Physician's Rewrite					
		st 2012 including, but not					
	limited to,						
	An order origina	lly received 3/27/12, for					
		nt of PEG tube every					
	•	ninistering meds" and					
	_	r to and after medication					
	administration w						
	danninstration w	itii 5000 water.					
	a. An order orig	inally received 4/26/12,					
	for "Metoclopramide 5mg/5ml sol [solution], give 5 ml (5 mg) four times						
		minal pain." The orders					
	indicated the firs	•					
		0 a.m., and the second					
		led at 1:00 p.m. The first					
		stered at least 45 minutes					
	after the one hou	r before/after the					
	scheduled dosing	g time.					
		-					
	b. An order origi	inally dated 3/28/12, for					
	"Budesonide IN	H 0.5mg/2ml, use 1 vial					
	per nebulizer twi	ice daily." The orders					
	indicated the firs	st daily dose was					
	scheduled at 9:0	0 a.m. was administered					
	at least 45 minut	es after the one hour					
	before/one hour	after the scheduled					
	dosing time. Th	e resident also received a					
		er medication at 6:00					
	a.m. and 12 nooi	1.					
		inally dated 5/16/12, for					
	"Carvediol 3.125	5 tablet, 1 by mouth twice					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 27 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155203	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 08/21/2012
	PROVIDER OR SUPPLIER EST VILLAGE	203 SP	ADDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION
	daily. Hold if systolic blood pressure is <90 [less than 90]." The orders indicated the medication was scheduled at 9:00 a.m. and 5:00 p.m. The medication was administered at least 45 minutes after the one hour before/one hour after scheduled dosing time. The medication was administered by gastrostomy tube. During interview on 8/21/12 at 11:35 a.m., RN #13 indicated Resident F receives a tray but does not eat well. She indicated the resident takes all her medications through the gastrostomy tube. The pharmacy policy for Medication Administration Guidelines was provided by the Medical Records Nurse on 8/21/12 at 2:20 p.m. The policy included, "Medications can be administered within a two hour time frame (one hour before to one hour after the time prescribed)Administering medications too early or too late is considered a medication error" This federal tag relates to Complaints IN00113535, IN00113621, and IN00114469. 3.1-25(b)(9) 3.1-48(c)(1)			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 28 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	(X2) MULTIPLE CO A. BUILDING B. WING	00		ESURVEY LETED 1/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 29 of 46

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155203	B. WING		08/21/2012
NAME OF B	DOLUDED OD GUDDUIE		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	K	203 SF	PARKS AVE	
HILLCRE	ST VILLAGE		JEFFE	RSONVILLE, IN 47130	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0425 SS=E	PROCEDURES, The facility must emergency drugs residents, or obta agreement descripart. The facility personnel to administration of a land permits, but only supervision of a land permits, and and biologicals) the facility must services of a lice provides consultate provision of phare. The facility must services of a lice provides consultate provision of phare. A. Based on obtain and interview, the policies related to followed for residentification afficient practice identification afficient practice. B. Based on obtain and interview, the pharmacy provides the pharmacy provides and interview, the pharmacy provides and interview, the pharmacy provides and practice deficient practice.	provide routine and s and biologicals to its ain them under an ribed in §483.75(h) of this may permit unlicensed ninister drugs if State law under the general licensed nurse. ovide pharmaceutical ng procedures that assure	F0425	What corrective action(s) will be accomplished for those residents found to have beer affected by the deficient practice? All residents have identifiers in the MARs and TAR's. Resident A's is receiving medications per physician orders and standards of nursing practice. How other residents having the potentiat to be affected by the same deficient practice will be identified and what correctivaction(s) will be taken? All residents have the potential be affected by the alleged	ing al
	sample of 11. ()	Residents A and E)		deficient practice.All residen	ts

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 30 of 46

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155203				08/21/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE	
					ARKS AVE	
HILLCRE	ST VILLAGE			JEFFEF	RSONVILLE, IN 47130	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					MAR's and TAR's were	
	Findings include	•			reviewed to ensure identifier	s
	Tillulings illerude	·•			were in place by	
					DNS/Designee. All residents	
	A.1. The pharm	acy policy for Medication			medications were reviewed to	o
	Administration (Guidelines was provided			ensure medications prescrib	ped
	by the Medical Records Nurse on 8/21/12				were available as ordered by	
		2:20 p.m. The policy included, but was			DNS/Designee. Pictures were	
	-	t limited to, "Before giving a			taken of all residents and are	
		mited to, "Before giving a cation, the nurse must follow the			present in their MAR's and TA	
	-				for identification. New admission	ons
	FIVE "R's": TH	E RIGHT RESIDENT			to the facility will have their	
	After the residen	t has been identified,			pictures taken by nursing	
	and the medication has been given"				administration/designee and	
		cy for Identification of a			placed in their MAR/TAR.Licensed nurses wi	
		ed, "This facility will			be educated on re-ordering	11
					medications timely to ensure	
	•	to identify the resident			allmedications are available as	
	by use of an ider	ntification bracelet and/or			prescribed by their physicians	
	current photogra	ph of each residentIf			the Pharmacy consultant on o	
	photographs are	used for resident			before 9/20/12.Night shift nurs	• • • • • • • • • • • • • • • • • • •
		notographs of the resident			will be responsible to check m	
	_	nission, and with any			carts daily to ensure medication	ons
		_			are re-ordered before current	
	_	ge while residing in the			supply exhausts.The	
		otographs should be			DNS/designee is responsible f	
	placed in the Me	edication Administration			complianceNon-compliance w	itn
	Record. Identifi	cation on bracelet and			these practices will result in	
	photograph inclu	ides resident name, room			further education includingdisciplinary action. W	/hat
		on date, and attending			measures will be put into pla	• • • • • • • • • • • • • • • • • • •
	•	photograph is missing or			or what systemic changes wi	
					be made to ensure that the	
	_	te, a new photograph will			deficient practice does not	
	-	ced in the designated			recur? The charge nurses are	
	area."				responsible for ensuring the	
					pictures are in present on the	
	During interview	on the Initial Tour on			MAR's and TAR's for	
	_	a.m., RN #9 indicated she			identification. Any areas of	
		· ·			non-compliance will be	
	was new to the f	acility and was slow on				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPL	ETED
		155203	B. WIN			08/21/	2012
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		1			
LIILLODE	CT VIII I ACE				ARKS AVE		
HILLUKE	EST VILLAGE			JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	the medication p	bass yesterday, because			immedicately reported. New		
	_	g the residents' names and			admissions to the facility will h		
	their medications. She indicated she had				their pictures taken by the nurs	sing	
					administration/designee and		
		o was who to be sure she			placed in their		
		ident. She indicated not			MAR/TAR.Licensed nurses wi	II	
	all residents had	pictures in the			be educated on re-ordering medications timely to ensure		
	Medication Adn	ninistration Record, and			allmedications are available as	2	
	from the picture	s she wasn't always sure			prescribed by their physicians		
	who the resident				the 5 rights for administering		
	who the resident	do Wele.			medications by the Pharmacy		
	D : 64 N	e 1			consultant/Designee on or bef	ore	
		Review of the Medication Administration			9/20/12.Night shift nurses will	be	
	Record binders	on 8/20/12 at 3:40 p.m.			responsible to check med		
	indicated the fol	lowing:			carts daily to ensure medication	ns	
					are re-ordered before current		
	2-South (two bir	nders): 23 residents had			supply exhausts.The		
	`	1 5 residents had no			DNS/designee is responsible f		
		13 residents had no			compliance.Non-compliance w	/IUT1	
	photographs;				these practices will result in further education		
					includingdisciplinary action Ho	.A/	
	2-East: 19 resid	ents had photographs and			the corrective action(s) will b		
	7 residents had r	no photograph;			maintained to ensure the		
					deficient practice will not rec	ur.	
	Transitional Car	e Unit: 8 residents had			i.e., what quality assurance	···,	
		1 14 residents had no			program will be put into plac	e?	
		1 14 lesidents nad no			The CQI tools for pharmacy		
	photograph.				services and resident		
					identification will be utilized		
	During interview	v on 8/21/12 at 9:30 a.m.,			weekly x4, monthly x6 and		
	the Administrate	or indicated residents'			quarterly thereafter Findings		
	photographs had	I now been printed out of			from the CQI process will be		
		placed on the Medication			reviewed monthly and an		
	Administration 1				actionplan will be implement	ed	
	Administration	ixecutus.			as needed for any deficient		
					practices below 95% threshol	d.	
		2 [Sunday] at 10:25 a.m.,			The CQI team will determine		
	LPN #15 was ob	oserved preparing			need for further review		
	medications for	Resident A. During					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 32 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155203	A. BUII B. WIN	DING	00	COMPL 08/21/	ETED
	PROVIDER OR SUPPLIER	•	203 SPA	DDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	interview at this time, LPN #15 indicated the resident had a dose of Avapro due, but the medication was not on the medication cart, and she would need to check the EDK (Emergency Drug Kit) for the medication. LPN #15 and administered the medications prepared. She proceeded to the Medication Room, checked the EDK, and indicated the medication was not in the EDK. The medication was not administered. B.2. On 8/19/12 [Sunday] at 10:40 a.m., LPN #15 was observed preparing medications for Resident E. During interview at this time, LPN #15 indicated the resident also should receive a dose of Alfuzosin, but the medication had not yet been received from the pharmacy. LPN #15 indicated that sometimes on the week-end the pharmacy is slow to deliver medications. The medication was not administered. The facility's policy for "Delivery Schedule" was provided by the Medical Records Nurse on 8/21/12 at 2:20 p.m. The policy included, but was not limited to, "[Name of facility's pharmacy] will have a minimum of one scheduled delivery per day, Monday thru Saturday, with the delivery leaving the pharmacy at approximately 9:00 p.m. (subject to change). Note: There is no scheduled					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 33 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155203	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 1/2012
	PROVIDER OR SUPPLIER	203 SP	ADDRESS, CITY, STATE, ZIP CO ARKS AVE RSONVILLE, IN 47130	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
			CROSS-REFERENCED TO THE AIDEFICIENCY)	PPROPRIATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 34 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	00	COMPL	
		155203	B. WING			08/21/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					ARKS AVE		
HILLCRE	ST VILLAGE		JE	EFFER	SONVILLE, IN 47130		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL	PRE		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
F0431	483.60(b), (d), (e)						
SS=D	& BIOLOGICALS	S, LABEL/STORE DRUGS					
		employ or obtain the					
		nsed pharmacist who					
		tem of records of receipt					
	•	fall controlled drugs in					
		enable an accurate					
		d determines that drug ler and that an account of					
		gs is maintained and					
	periodically recon						
		icals used in the facility					
		n accordance with currently ional principles, and					
		priate accessory and					
		ctions, and the expiration					
	date when applica	able.					
		th State and Federal laws,					
	the facility must s	ed compartments under					
	•	re controls, and permit only					
		nnel to have access to the					
	keys.						
	The feetile 1	ddt-b ! ! !					
		orovide separately locked, ed compartments for					
		led drugs listed in					
	_	Comprehensive Drug					
	Abuse Prevention	and Control Act of 1976					
		ubject to abuse, except					
		uses single unit package					
		systems in which the minimal and a missing					
	dose can be read	•					
		ation, record review, and	F0431		What corrective action(s) will		09/20/2012
		cility failed to ensure			be accomplished for those		
	-	e labeled in accordance			residents found to have been		
		olicies. The deficient			affected by the deficient		
	Trui pharmacy p	onores. The deficient			practice?Resident D		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 35 of 46

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155203	B. WIN			08/21/2012	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF P	ROVIDER OR SUPPLIER				ARKS AVE		
	ST VILLAGE				RSONVILLE, IN 47130		
HILLOKE	ST VILLAGE			JEFFER	RSONVILLE, IN 47 130		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	1
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	practice related t	o labeling affected 2 of 6			medications are appropriate		
	residents whose	medications were			labeled. Resident F		
	observed related	to labeling in a sample of			medications have a new labe	1	
	11. (Residents I				per pharmacy policy. How		
	11. (Residents L	and r)			other residents having the		
					potential to be affected by the	•	
	Findings include	:			same deficient practice will b		
					identified and what corrective)	
	1. On 8/19/12 at	10:05 a.m., LPN #15 was			action(s) will be taken?All	_	
		ng medications for			residents have the potential t	°	
		uding an Advair inhaler.			be affected by the alleged		
	•	_			deficient practice.Licensed		
		not in a baggie with a			nurses will be educated on pharmacy policies regarding	_	
	· ·	sident's name was not on			labeling ofmedications by the	³	
	the inhaler canis	ter. LPN #15 looked in			Pharmacy consultant on or bet	ore	
	the medication d	rawer, and during			9/20/12, post test included.A		
	interview at this	time, she indicated she			100% audit of all medications	will	
		nd the labeled baggie for			be completed to ensure all lab		
		vair. She indicated she			are legible and present by the		
					pharmacy consultant. Labels		
	_	d to the resident, because			found not meeting pharmacy		
	•	resident using an Advair			policies will be replaced.The D	NS	
	inhaler. LPN #15	also indicated the			will be responsible for		
	resident's name v	was not on the inhaler			complianceNon-compliance wi	tn	
	canister.				these practices will result in further education		
					includingdisciplinary action Wh	at	
	2 On 9/10/12 -4	10:45 a m I DN #15			measures will be put into pla		
		t 10:45 a.m., LPN #15			or what systemic changes wi		
	•	eparing medications for			be made to ensure that the	"	
		N#15 obtained a bottle of			deficient practice does not		
	Metoclopramide	5mg/5ml from the			recur? Licensed nurses will be	.	
	medication draw	er. She indicated a spill			educated on pharmacy policies		
		he information on the			regarding labeling ofmedication	•	
		. She was observed to			by the Pharmacy consultant or	ı or	
					before 9/20/12, post test		
		the medication into a			included.A 100% audit of all		
	medication cup.				medications will be completed	to	
					ensure all labels are legible		
	The facility's pol	icy for "Labeling of			and present by the pharmacy		
			1			1	

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 00		(X3) DATE SURVEY COMPLETED	
MIDILAN	155203	A. BUILDING		08/21/2012	
	100200	B. WING	ADDRESS OF THE STREET	00/21/2012	
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE ARKS AVE		
HILLCRE	EST VILLAGE		RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	
	Medication" was provided by the Medical		consultant. Labels found not		
	Records Nurse on 8/21/12 at 2:20 p.m.		meeting pharmacy policies wil	I be	
	The policy indicated the following:		replaced. Charge Nurses are responsible for ensuring that t	he	
	"6.02 Medication Labeling: Medication		medications have the appropr		
	labels are not to be: Dirty, illegible,		label and legible during their n	• • • • • • • • • • • • • • • • • • •	
	defaced, altered, or revised. When the		pass each shift. Pharmacy wil		
	label becomes soiled and/or illegible the		notified if replacement labels a indicated. The DNS wil be	are	
	medication will be destroyed in		responsible for		
	accordance with State and Federal		complianceNon-compliance w	ith	
	Laws" The policy also indicated,		these practices will result in		
	"6.10 Difficult Labeling: When it		further education		
	becomes difficult to attach the medication		includingdisciplinary action Hother corrective action(s) will be		
	label directly to the medication container		maintained to ensure the		
	because of size or shape, [name of		deficient practice will not red	eur,	
	pharmacy provider] will attach the		i.e., what quality assurance		
	medication label to the companion box or		program will be put into place	• • • • • • • • • • • • • • • • • • •	
	baggie or vial and insert the medication		The CQI audit tool for pharm services will be utilized weel	-	
	container. The medication container will		x4, monthly x6 and	у	
	have a small auxiliary label attached to it		quarterly thereafter Findings fi	rom	
	which contain the following information:		the CQI process will be review		
	Patient Name, Medication Name and		monthly and an action plan wi		
	strength (if applicable), Quantity		implemented as needed for ar deficient practices below 95%	ıy	
	dispensed, Rx [prescription] number,		threshold. The CQI team will		
	Date dispensed, Directions for Use. After		determine need for further		
	the medication is used it must always be		review.		
	returned immediately to the labeled box,				
	baggie, or vial"				
	000000000000000000000000000000000000000				
	This federal tag relates to Complaints				
	IN00113535, IN00113621, and				
	IN00114469.				
	1100111107.				
	3.1-25(k)(1)				
	3.1-25(k)(1) 3.1-25(k)(2)				
	J.1-2J(K)(Z)				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 37 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/21/2012			
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-25(k)(3) 3.1-25(k)(4) 3.1-25(k)(5) 3.1-25(k)(6) 3.1-25(k)(7)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 38 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155203	B. WING		08/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L		PARKS AVE	
HILLORE	ST VILLAGE			RSONVILLE, IN 47130	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0441	483.65	ITPOL PREVENT			
SS=E		ITROL, PREVENT			
	SPREAD, LINEN	s establish and maintain an			
	•	Program designed to			
		anitary and comfortable			
		to help prevent the			
		transmission of disease			
	and infection.				
	(a) Infection Cont				
	•	establish an Infection			
	Control Program				
		controls, and prevents			
	infections in the fa	•			
		procedures, such as be applied to an individual			
	resident; and	be applied to all illulvidual			
	•	ecord of incidents and			
	` '	related to infections.			
	(b) Preventing Sp	read of Infection			
	· · ·	ection Control Program			
		resident needs isolation to			
		nd of infection, the facility			
	must isolate the r				
		ust prohibit employees with			
		disease or infected skin ct contact with residents or			
		t contact will transmit the			
	disease.	t contact will transmit the			
		ust require staff to wash			
		each direct resident contact			
	for which hand wa	ashing is indicated by			
	accepted profess	ional practice.			
	(c) Linens				
		nandle, store, process and			
	-	o as to prevent the spread			
	of infection.	adian indomnian and	F0441		00/20/2012
		ation, interview, and	F0441	What corrective action(s) wi	II 09/20/2012
	record review, th	ne facility failed to ensure		be accomplished for those	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 39 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		155203	B. WING 08/21/2012				
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L.			ARKS AVE		
HILLCREST VILLAGE					RSONVILLE, IN 47130		
	SUMMARY STATEMENT OF DEFICIENCIES		1		,	(VI)	
(X4) ID PREFIX		CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
1110		, , , , , , , , , , , , , , , , , , ,		1710	residents found to have been	5.112	
	hand washing an				affected by the deficient		
		the facility's infection			practice?Resident D shows n	10	
	•	for 5 of 7 residents			evidence of harm by alleged		
		care from a sample of 11			deficient practice.Resident A,		
	residents. (Resi	dents D, A, E, F, and K)			Resident E, Resident F,		
					and Resident K are recieving		
	Findings include: 1. On 8/19/12 at 10:05 a.m., LPN #15 was observed at the medication cart preparing medications for Resident D. LPN #15 dispensed medications from blister pack cards, popping the medications from the cards into her				appropriate care based on the		
					infection control policies and		
					practices. How other resident	s	
					having the potential to be affected by the same deficien	.+	
					practice will be identified and		
					what corrective action(s) will		
					be taken?All residents have t	I	
					potential to be affected by the	· ·	
					alleged deficient		
	ungloved fingers	and placing the			practice.Nursing Staff will		
	medications in a	medication cup. The			be re-educated on hand washi	ng,	
	resident's Digoxi	in tablet dropped onto the			use of gloves policy and		
		ation cart, and the nurse			procedures by the SDC/design	nee	
	picked it up and				on or before 9/20/12 with post test included. Skills checks will	he	
	medication cup.	-			completed for nursing staff by		
	_				SDC/designee on or before		
	, ,	hered medications for			9/20/12.DNS/designee will be		
		nent, and entered the			reponsible for		
		LPN #15 obtained cups			outcomes.Non-compliance with	h	
		e bathroom for use during			these practices will result in		
	administration of	f the medications by			further education including disciplinary action What		
	gastrostomy tube	e. She donned gloves,			measures will be put into pla	re l	
	administered the	medications by			or what systemic changes wi	I	
		e, removed the gloves,			be made to ensure that the	••	
	"	hing her hands or using			deficient practice does not		
		dministered the inhalers.			recur? Nursing Staff will		
	· ·	icated she needed to be			be re-educated on hand washi	•	
					use of gloves policy and infecti		
		th her tracheostomy tube.			control policy and procedures	•	
	·	g her hands or using hand			the SDC/designee on or before	9	
	sanitizer, LPN #	15 donned sterile gloves			9/20/12 with post test		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 40 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. Building 00		COMPLETED		
		155203	B. WING 08/21/2012			08/21/2012	
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF F	PROVIDER OR SUPPLIER	S.			ARKS AVE		
HILLCREST VILLAGE				RSONVILLE, IN 47130			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	N
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		DATE	
	and suctioned th	e resident. She removed			included.Skills checks will be	u	
	the gloves, and v	vithout washing her			completed for nursing staff by SDC/designee on handwashin		
	hands or using h	and sanitizer, returned to			and glove usage on/or before	9	
	the medication c	art, stored supplies, and			9/20/12.Nursing Administration	1	
	documented on t				will conduct daily rounds and		
	Administration I	Record.			monitor infection control practi		
					as it relates to handwashing a		
	2 Without wash	ning her hands or using			glove use.DNS/designee will b reponsible for	e	
		n 8/19/12 at 10:25 a.m.,			outcomes.Non-compliance wit	,	
	-	·			these practices will result in		
	LPN #15 began preparing medications for Resident A. She dispensed medication from blister pack cards, popping the				further education including		
					disciplinary actionHow the		
					corrective action(s) will be		
		n the cards into her			maintained to ensure the		
	ungloved fingers	s and placing the			deficient practice will not rec	ur,	
	medication into	a medication cup. LPN			i.e., what quality assurance program will be put into place	.,	
	#15 entered Resi	dent A's room, checked			The CQI audit tools for	<i>f</i>	
	her vital signs ar	nd administered her oral			infection control will be utiliz	ed	
	medications. W	ithout washing her hands			weekly x4, monthly x6 and		
		nitizer, she went to the			quarterly thereafter Findings		
	Medication Room				from the CQI process will be		
	Emergency Drug				reviewed monthly and an		
	, ,	Resident A. Without			action plan will be		
	washing her han				implemented as needed for a	ny	
	_	urned to the medication			deficient practices below 95%threshold. The CQI team	will	
	·	urned to the medication			determine need for further revi		
	cart.				22.3		
	3 On 8/19/12 at	t 10:40 a.m., LPN #15					
		medications for Resident					
		ding at the medication					
	-	sed medication from					
	blister pack card						
		n the cards into her					
	ungloved fingers	s and placing the					
	medication into	a medication cup. She					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 41 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203 20 20 20 20 20 2	
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE (X4) ID PREFIX TAG Checked the resident's heart rate with an electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m., STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130 (X5) PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PREFIX TAG OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PREFIX TAG OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PREFIX TAG OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PREFIX TAG OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PREFIX TAG OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PREFIX TAG OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PREFIX TAG OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OR PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY (E	
HILLCREST VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Checked the resident's heart rate with an electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	
HILLCREST VILLAGE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) checked the resident's heart rate with an electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Checked the resident's heart rate with an electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Checked the resident's heart rate with an electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) Checked the resident's heart rate with an electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	
checked the resident's heart rate with an electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	
electronic device and administered the medications. 4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	\dashv
4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	
4. Without washing her hands or using hand sanitizer, on 8/19/12 at 10:45 a.m.,	
hand sanitizer, on 8/19/12 at 10:45 a.m.,	
hand sanitizer, on 8/19/12 at 10:45 a.m.,	
LPN #15 began preparing medications for	
Resident F. She entered the resident's	
room with medications and supplies,	
obtained water for gastrostomy tube	
medications from the bathroom, donned	
gloves, and administered the resident's	
medications by gastrostomy tube. She	
removed her gloves, and without washing	
her hands or using hand sanitizer, she	
donned another pair of gloves and	
administered an injection into the	
resident's abdomen. She removed her	
gloves. Without washing her hands or	
using hand sanitizer, she used an	
electronic device to check the resident's	
oxygen saturation and set up the resident's	
nebulizer treatment. Without washing her	
hands or using hand sanitizer, she left the	
room, replaced electronic devices in the medication cart, and indicated she was	
ready to prepare medications for the next	
resident.	
5 O 9/21/12 4 12 10 m o CNIA //19	
5. On 8/21/12 at 12:10 p.m. CNA #18	
and the Director of Nursing (DON) were	
observed in the room of Resident K	
preparing to transfer the resident from bed	
to chair with a Hoyer lift. The resident	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 42 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155203	A. BUILI B. WINC	DING	<u>00</u>	COMPL 08/21/	ETED	
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 SPARKS AVE JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	was observed to have a dark red rash area on the right side of the back at the waistline. The DON was interviewed about the rash. She began to look at the area and was observed to touch the resident's skin near the rash area with an ungloved hand, as she leaned in to see more clearly. She then indicated, "Let me get" and stepped to the glove dispenser on the wall. She donned gloves and completed the assessment. She indicated the resident's nurse just left the room to get an order for treatment to the rash. The facility's policy for "Gloves" was provided by the Medical Records Nurse on 8/21/12. The policy indicated hands are washed before putting on and after taking off gloves. 3.1-18(1)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 43 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		ER:	LDING G	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/21/2012
NAME OF PROVIDER OR SUPPLIER HILLCREST VILLAGE			203 SP	DDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN 47130	
(X4) ID PREFIX TAG F0514 SS=D	SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BE REGULATORY OR LSC IDENTIFYING INFOR 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE// SSIBLE The facility must maintain clinical record each resident in accordance with acceptance of the state of the	ACCE ds on opted	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
	professional standards and practices the are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a resofther resident's assessments; the plant care and services provided; the results any preadmission screening conducted the State; and progress notes. Based on observation, interview, and	ent ecord of of d by	14	What compative action(a) will	09/20/2012
	record review, the facility failed to e documentation on the Weekly Skin Assessment was complete and accur for 1 of 11 residents reviewed relate accurate documentation in a sample residents. (Resident K) Findings include: On 8/19/12 at 8:10 a.m., Resident K observed receiving personal care. A skin rash area was observed on the riside of the resident's back near the waistline. During interview at this tic CNA #18 indicated she had observed cream on the area previously. On 8/19/12 at 12:15 p.m., the Administrator indicated "skin sweep	was red ight ime, d	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident K was re-assessed and an accurate assessment was completed and placed in the medical record. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practiceLicensed nurses will be re-educated on the policy/procedure on completing weekly skin assessments by the SDC/designee on or before 9/20/12 with post test included. A 100 % facility skin sweep will be conducted on or before 9/20/12 to ensure residents with		nt d l l l l l l l l l l l l l l l l l l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 44 of 46

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE S	X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
		155203	B. WING 08/21/2012			2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	R			ARKS AVE		
HILLCREST VILLAGE			1	RSONVILLE, IN 47130			
HILLORE	IILLURES I VILLAGE			JEFFER	RSONVILLE, IN 47 130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	had been just be	een completed on 8/19/12			any alteration in skin integrity		
	on Resident K's	unit. The Administrator			have all components complete	;	
	nrovided a conv	of the "Weekly Skin			(i.e. MD/family ntoification,		
		Resident K, dated			treatment ordered, weekly		
					measurements/monitoring). Charge nurses will conduct		
	8/19/12. In the blank following "Discoloration/Rashes" was a check mark next to "No."				weekly skin assessments and		
					results of the assessment will	he	
					documented.DNS/designee wi		
					be responsible for		
	On 8/21/12 at 12	2:10 p.m., Resident K was			compliance.Non-compliance w	/ith	
	observed in bed. On the right side of the resident's back near the waistline was observed a dark red skin rash area. A small red line of rash was observed on the left side of the resident's back. During				these practices will result in		
					further education including		
					disciplinary action. What		
					measures will be put into pla		
					or what systemic changes w	ill	
					be made to ensure that the		
	interview at this	time, the Director of			deficient practice does not		
	Nursing indicate	ed Resident K's nurse had			recur? All residents have the		
	_	n and was contacting the			potential to be affected by the	aad	
	-	order for treatment of the			alleged deficient practiceLicen nurses will be re-educated on		
		order for treatment of the			policy/procedure on completing		
	area.				weekly skin assessments by the		
					SDC/designee on or before		
	3.1-50(a)(2)				9/20/12 with post test included	l.A	
					100 % facility skin sweep will b	ре	
					conducted on or before 9/20/1	2 to	
					ensure residents with		
					any alteration in skin integrity		
					have all components complete)	
					(i.e. MD/family ntoification, treatment ordered, weekly		
					measurements/monitoring)DN	S/d	
					esignee will be responsible for		
					compliancenon-compliance wi		
					these practices will result in		
					further education including		
					disciplinary action. How the		
					corrective action(s) will be		
					maintained to ensure the		
					deficient practice will not rec	ur,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet Page 45 of 46

PRINTED: 09/20/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155203	A. BUILDING	00	COMPI 08/21	LETED
		100200	B. WING	ADDRESS OF A STATE OF		12012
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODI ARKS AVE	3	
	ST VILLAGE			RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	i.e., what quality assurar program will be put into The CQI audit for skin management program wutilized weekly x4, month and quarterly thereafter Findings from the process will be reviewed and an action plan will be implemented as needed for deficient practices below threshold. The CQI team with determine futher need for the process of the process o	nce place? ill be nly x6 he CQI monthly or any 95% will	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WXTL11

Facility ID: 000110

If continuation sheet

Page 46 of 46